WISCONSIN MEDICAID EVALUATION

Therapy Provider Training CD-ROM

Name (optional) _____

Agency _____

Occupational Therapist ☐ Physical Therapist ☐ Speech-Language Pathologist ☐

Reaction to CD-ROM	Excellent	Good	Fair	Poor
Format	☐	☐	☐	☐
Helpfulness	☐	☐	☐	☐
Content	☐	☐	☐	☐
Organization	☐	☐	☐	☐

What you liked most about the CD-ROM: _____

What you would like to see changed on a future CD-ROM: _____

Additional Comments or Questions: _____

Return this form to: Therapy Policy Analyst, Division of Health Care Financing
P.O. Box 309, Madison, WI 53701-0309